

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

May 25, 2016

Mr. Edgar Greason, Administrator Country Village Community Care Home 99 Atkinson Street Bellows Falls, VT 05101-1302

Dear Mr. Greason:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on May 4, 2016. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN Licensing Chief

nlaMCVaRN

ATE FORM

PRINTED: 05/10/2016 FORM APPROVED

_ Division	of Licensing and Pro	otection				7 01 1101	ALLINOVED
	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIE IDENTIFICATION NU		1	LE CONSTRUCTION	(X3) DATE	SURVEY PLETED
		0018		B. WING			C 04/2016
NAME OF	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	STREET AD	INDESS CITY	STATE, ZIP CODE		
	THO THE NOT BOTT ELEK			SON STREE	·		
COUNTR	RY VILLAGE COMMUN		BELLOW	S FALLS, VI			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
R100	Initial Comments:			R100			
-	was conducted by t	n-site complaint inve he Division of Licens 5. There were regula	ing and		Please see attached plans correction)f	
R114 SS=D	V. RESIDENT CAR	E AND HOME SER\	/ICES	R114			
	5.3 Discharge and	Transfer Requireme	nts	:			
	5.3.a Involuntary D Residents	ischarge or Transfe r	of				_
	(2) In the case of ar transfer, the manag	n involuntary discharq er shall:	ge or	' i			;
	member and/or legaresident, of the disc specific reasons for language and mann at least 72 hours be home and thirty (30) the home. If the res member or legal rep assistance, the notic Term Care Ombuds	ot, and if known, a far all representative of the harge or transfer and the move in writing a ter the resident under fore a transfer within days before discharts sident does not have bresentative and requires shall be sent to the man, Vermont Protect total Senior Citizens La	ne d the and in a rstands the rge from a family uests e Long ction and				
	agency for giving wr transfer and include the resident has the decision to transfer a appropriate informat i.i. Include a statem	scribed by the licens itten notice of discha a statement in large right to appeal the hor discharge with the tion regarding how to ent in the written notinain in the room or he	print that ome's do so.				
ivision of Lic	ensing and Protection						
AEORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENT	ATWE'S SIGN	ATURE	TITLE		(X6) DATE

Division	of Licensing and Pro	tection					
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUC			E SURVEY PLETED
		0018	B. WING			05/	C 04/2016
NAME OF I	PROVIDER OR SUPPLIER	CTOEET AD	DBESS CITY	STATE, ZIP CO	NE	, 00,	0 112010
NAME OF	PROVIDER OR SUPPLIER		SON STREE		DE		
COUNTR	RY VILLAGE COMMUN	HIV CARE BOME	S FALLS, V				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORR CORRECTIVE ACTION SI REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
R114	Continued From pa	ge 1	R114	To be	in place	by	6/1/6
	during the appeal.		1		V	J	
	iv. Place a copy of clinical record.	the notice in the resident's		i			<u>;</u>
	This REQUIREMEN	IT is not met as evidenced	:				
	facility failed to notif sample, Resident # according to state re	view and record review, the y 1 of 2 residents in the 1, of an involuntary discharge egulations at least 30 days om the home. Findings					
	fall on 1/14/16 and p 1/15/16, the adminis see the resident. It s/he informed Resid fall and doesn't allow and doesn't call for ladministrator at 1:10 discharge notice is mot given and s/he s the resident that s/he back to the facility at The house manager	mitted to the hospital after a per progress note dated strator went to the hospital to is further documented that lent #1 that s/he continues to with the facility to help him/her help. Per interview with the D PM, s/he stated that if the not in the chart, then it was stated that s/he verbally told e was not allowed to come and was being discharged. It confirmed at 1:45 PM that ce of a discharge notice lent #1.					
R123 SS=D	V. RESIDENT CARE	EAND HOME SERVICES	R123				
	5.4 Refunds						
	resident shall receive	ent is discharged, the e a refund, within 15 days of inds paid in advance for each					

Division of Licensing and Protection STATE FORM

31-

6599

CON JEASON

Division of Licensing and Prote	ection			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
^	0018	B WING		C 05/04/ 2016
				1 03/04/2016
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE	
COUNTRY VILLAGE COMMUNI	LY CARE HOME	NSON STREE VS FALLS, V		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES NUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CRDSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETE
discharge to a hospit placement, the effect shall be the day the hwill not be returning. providing refunds, "doconsidered the day the form the resident's beloware too large or difficutemporarily. The facility small items such as continuous items if necessary. This REQUIREMENT by: Based on staff intervificatility failed to provide discharge from the facility failed to provide financial information account for doesn't show individual Resident #1 was supply would have given it to check on the status of	all or other temporary live date for this provision nome is notified the resident. For the purposes of ay of discharge" shall be ne resident's room is emptyingings, if those belongings wit for the home to store lity shall temporarily store clothing and other personal. If is not met as evidenced lew and record review, the die a refund within 15 days of citity for 1 of 2 residents, is include: With the administrator at that he does not keep any at the facility and does not as made a payment. She syments are deposited in the Country Village and it all names. She said that if posed to get a refund he of them and that she would if the refund when she	. R123	to be in place to	Dey 6/1/6
kept. When the admi 1:15 PM and stated the financial statements s	the financial records are instrator called the facility at nat after reviewing the she confirmed that there is resident received a refund ischarge.			
R187: V. RESIDENT CARE SS=B	AND HOME SERVICES	! R187	to be in place!	3 6/·/16
v.sion of Licensing and Protection			1	·

<u>Division</u>	of Licensing and Pro	<u>tection</u>			FORM APPROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	t	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		0018	B. WING		C 05/04/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DORESS, CITY, S	TAYE ZIP CODE	1 00/04/2010
COUNTS	RY VILLAGE COMMUN	00 474.4	ISON STREET	"	
	T VILLAGE COMMON		S FALLS, VT		
(X4) :U PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID : PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
R187	Continued From pa	ge 3	R187		i
	5.12.b. (1)		į		
! :	A resident register transfers out of the	including all discharges, home and admissions.			
:	by:	IT is not met as evidenced		*	
	facility failed to mair	view and record review, the stain a resident register that ges, transfers out of the home adings include:			ļ
	review contained on reflected a discharg house manager s/he the administrator to	r that was presented for ly 24 names and only one e. Per interview with the e stated that s/he would notify get assistance with locating			
ļ	yearly fists of resider for 2010 - 2013, but discharges to other incomplete. The ho	use manager presented nts that had been hospitalized there is no indication of places and the data is use manager stated, at 12:35			
	PIV, that the register does not reflect discharged residents and it does not contain the names of all the residents that have resided at the facility. The administrator confirmed, via phone interview at				
!	1:10 PM, that s/he h	ad destroyed the original ted a new one with the			
R226 \$S=D	VI. RESIDENT'S RIC	SHTS	R226		
		ect to transfer or discharge or Section 5.3 of these			
(6.14.a Be allowed to	participate in the			
vision of Lice	ensing and Protection				

Division of Licensing and Protection STATE FORM

6899

HYLIN APPALASION

If continuation sheet, 4 of 6

_Division	of Licensing and Pro	otection					FORM	APPROVED
STATEME	NT.OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCT	ON		Livor Dame	OURS
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		G:			(X3) DATE COMP	SURVEY LETED
<u></u>) A. BUILBIN	·				
		0049	B Manc				C	;
		0018	B. WING				05/0	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREE	TADDRESS, CITY	, STATE, ZIP COD)E			
COUNTE	OV MILE A CE CORARRIZA	20.45	KINSON STRE					
COUNT	RY VILLAGE COMMUN		OWS FALLS, \					
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES						
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX	FRO FACH	VIDER'S PLAN I CORRECTIVE A	OF CORRECTION SHOULD	DOE I	(X5)
TAG	REGULATORY OR LS	SCIDENTIFYING INFORMATION)	TAG	CROSS-F	REFERENCED TO	O THE APPROI	PRIATE	COMPLETE DATE
			!		DEFICIE		!	
R226	Continued From page	ae 4	R226		-1		1	1
	!	•		to be	hy fight	es ple	ie by	61,110
	decision-making pro	ocess of the home concerni	ing		J	•		' 1 -
	the selection of an a	alternative placement;		!			\bigcirc	Ì
ı	614 b Deseive - d.		į					
	transfer; and	equate notice of a pending	İ					
,	transier, and							
	614 c Be allowed to	o contest their transfer or	1				;	ĺ
i	discharge by filing a	request for a fair hearing		•				
	hefore the Human 9	request for a fair flearing Services Board in accordance	:	İ			ļ	ļ
;	with the procedures	in 3 V S A E2004	ce					
	with the procedures	III 5 V.S.A. 93091.)]
							1	
	This REQUIREMEN	T is not met as evidenced	ŀ					i
	by:	, to not met as evidenced					i	
•		riew and record review, the	1					
1	facility failed to allow	1 of 2 residents, Resident	İ			•		
	#1, to participate in t	he decision-making proces	e	' •				
1	concerning the select	ction of alternative placemen	nt	İ				
i	and failed to provide	adequate notice of a	1				ì	Í
!	pending transfer. Fir	ndings include:					j	ı
		,					i	l
	Review of the record	for Resident#1 did not					ļ	
1	provide evidence that	at the resident was allowed	to .			4		Į
	participate in the dec	cision-making process for						
	alternative placemen	it and was not provided with	η ,					
	adequate notice of a	pending discharge.						
1	Resident #1 was adn	nitted to the hospital after a	'	l			,]
į.	fall on 1/14/16 and pr	er progress note dated						
	1/15/16, the administ	trator went to the hospital to	> :				<u>'</u>	
	see the resident. It is	s further documented that	!	i			!	
	s/he informed Reside	ent #1 that s/he continues to)					
	fall and doesn't allow	the facility to help him/her						i
i	and doesn't call for h	elp. Per interview with the	:					
ä	administrator at 1:10	PM, s/he stated that if the	į			•	į	j
: (discharge notice is ni	ot in the chart, then it was		I			:	. 1
J	not given and s/he sta	ated that s/he verbally told	:					ľ
t	the resident that s/he	was not allowed to come						
ŀ	pack to the facility an	d was being discharged.						
_	The house manager (confirmed at 1:45 PM that		!				
t	here was no evidenc	e of a discharge notice						

Division of Licensing and Protection STATE FORM

6599

3HYL11, ON JACL

STATE FORM

Division of Licensing and Protection

PRINTED: 05/10/2016 FORM APPROVED

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			CONSTRUCTION		E SURVEY MPLETED
		0018		8, WING		05	C / 04/2016
NAME OF PR	OVIDER OR SUPPLIER	<u>-</u> .	STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE		
COUNTRY	VILLAGE COMMUN	NITY CARE HOME		SON STREET			
,				S FALLS, VT			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
R226 C	Continued From pa	ge 5	:	R226			
þ	eing given to the r	esident.					
			:				
:			-				
<u> </u>							!
				· 			,
!							
			i i				
:							
Division of Licer STATE FORM	ising and Protection		6	⁶⁹⁹ 3H	YLII WAS	SOU if contin	uation sheet 6 cf

May 24 16 04:58a

CVCC

8024631986

Survey response 5/4/16

R114

Country Village will follow proper procedure for Involuntary discharge or transfer of resident as stated in Statement of deficiency. CVCC will add to its policy and procedures that Administrator, Manager, and Nurse will meet to discuss possible discharge and follow proper procedure to notify Resident, Family if available, and other concerned parties if decided to go forward with a Involuntary Discharge. This action will be monitored by administrator.

R123

CVCC will add to its Policy and Procedures that refunds are discussed and noted that a refund will be issued in the 15 day period allowed. This will be monitored by the Administrator.

R187

CVCC will maintain a Resident Register indicating Admission, discharge and/or readmission when hospitalized. Residents not returning to the Home will indicate placement. This deficiency will be monitored by the Administrator.

R226

As an extension of deficiency R114, If it is decided that a involuntary discharge is in order, the resident will be invited to join the Administrator, Manager and Nurse to discuss discharge and the Residents Rights to contest decision, remain in place in the home and request a fair hearing before the Human Services Board. This action will be monitored by the Administrator.